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**Asymmetrical translations of biomedicine in India: The cases of
contemporary Ayurveda and psychiatry**

Chopra, Ananda Samir ; Quack, Johannes

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Ladakh, August 2010



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Frontispiece

In August 2010, Ladakh in North India was hit by a natural disaster: cloudbursts, floods and mud slides caused the death of hundreds of people, and destruction all along the Indus river and in nearby areas. The picture shows the situation in the Tibetan refugee settlement Choglamsar the day following the disaster.

(photograph: Nike-Ann Schröder, see article this issue)

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Editors, Viennese Ethnomedicine Newsletter, Centre for Public Health, Unit Ethnomedicine and
International Health, Währinger Strasse 25, A-1090 Vienna, Austria
FAX: (+43)43-1-42779634, e-mail: ruth.kutalek@meduniwien.ac.at
homepage: <http://www.univie.ac.at/ethnomedicine>

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that they had died after being ritually burnt by MB. Kirwa's children stated that they heard of a neighbor who had died after fighting with his own father, but they were unaware that he was involved in killing their father until he made the confession at MB's "X-ray" session. However the alleged masterminds of their father's killing, who were well known to Kirwa's children since they had an affinal relationship with them, had not succumbed. They appeared in subsequent "outcome" sessions and claimed that they approached other healers to protect them from MB's fire. The remedy for such a case for MB was a new "hearing" and "judgment" session where the two would be set on fire together with their healers, followed by yet another "outcome" session. The case became protracted over several months in which MB set the masterminds on fire, and in subsequent outcome sessions, the enemies claimed to have approached new healers who protected them. In the last "outcome" sessions that I observed with Kirwa's children, the masterminds of their father's murder reported that they were fatally ill. I did not encounter Kirwa's children at MB's rituals again, but in subsequent discussions at their home, they concluded that MB had at least punished those who killed their father and it was just a matter of time before those who hired them also died. According to them MB's healing had addressed their concerns to their satisfaction.

Conclusion

Ritual healing is vibrant in Western Kenya and is neither a rejection of nor a resistance to modernity. In its comprehensive etiology, ritual healing accommodates and in some instances attempts to domesticate "modernity", as ritual healers and their clients grapple with the issues and problems occasioned by rapid societal

transformation. This societal transformation in the name of modernization has solved many problems as well as creating new ones, and it has also resulted in new avenues for dealing with old problems. Ritual healing played an important role in solving some of the problems faced by the people, since as one of my clients reiterated regarding his consultations with MB, "We are dealing with African chemistry here".

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Asymmetrical Translations of Biomedicine in India: The Cases of Contemporary Āyurveda and Psychiatry

Ananda Samir Chopra, Johannes Quack

Introduction

The spread of modern Western biomedicine to all parts of the world in the past two centuries

represents one of the most conspicuous examples of transcultural flows. This flow of biomedicine to different cultural and geographical contexts is informed by and again creates

asymmetries on different levels. By presenting two cases from India we endeavor to analyze the nature and effect of the transcultural flow of biomedicine and the asymmetries associated with it. Studying the practice of biomedical psychiatry in the context of a small Indian city, Johannes Quack examines the ways in which psychiatric concepts are made understandable to patients with a cultural background that is clearly different from the cultural background of biomedicine. Cultural and economic factors shape this process of translation as well as the practice of biomedical psychiatry. The theme of translation also looms large in Ananda Chopra's study of biomedicine's impact on contemporary Āyurveda. A scholarly medical tradition with a long literary history, Āyurveda reacts to biomedicine and its overwhelming claim to scientific truth in a complex way. On the institutional level the influence of biomedicine leads to a process of professionalization with the creation of āyurvedic institutions resembling biomedical ones. But on the conceptual level we find a complex process in the course of which Āyurveda incorporates biomedical knowledge in a peculiar way that is shaped by classical Indian notions of science.

The two projects presented here summarize the first findings of work in progress that is part of a larger research project called "Asymmetrical translations: Mind and body in European and Indian medicine" (C3) which investigates instances of "asymmetrical translations" in a trans-cultural perspective with respect to Indian systems of medicine in the West and Western systems of medicine in India. The central hypothesis is that flows of ideas and practices produced (and continue to produce) theoretical, practical, pedagogical, economic, aesthetic and other asymmetries within and amongst the European and South Asian healing systems. These asymmetries are exemplified as well as caused by practices of translation which we understand to include not only textual translation, but also pedagogics and therapeutics. In order to test, substantiate, qualify or correct this hypothesis the members of this project have been conducting research on transnational flows within and between the quartet of biomedicine, Āyurveda, psychology/psychiatry and vernacular healing, basing our investigation on learned and popular texts as well as on the ethnography of clinical and vernacular healing

practices. The central research question for all research projects is how texts and institutions (hospitals, medical schools, textbooks, doctors' reports, clinics, spas) of indigenous South Asian healing systems adapt to the dominant biomedical paradigm and vice versa. Further research questions address the different aspects of translation, spanning from the "translation of systems" over the "translation of practices" to the "translation of concepts" and their respective interconnections with nosologies and therapies.

One of the major strengths of the project is its inter-cultural and inter-disciplinary nature, with inputs from medical anthropology, religious studies, philology, history, and history of medicine. Besides the two authors, there are two doctoral students (Hari Kumar Nair and Christoph Cyrianski) and three other core team members working on the project "Asymmetrical Translations". The project is coordinated by William S. Sax who is exploring the ways in which terms and ideas associated with "Western" psychology penetrate North Indian popular culture. Bhargavi Davar is conducting an archival study of the ideational and institutional histories of psychology and psychiatry in India during the late colonial period. Finally, Harish Naraindas is working on the status of Āyurveda in the context of "complementary and alternative medicine" in Germany (see www.asia-europe.uni-heidelberg.de).

Psychiatry in India

The massive worldwide export of "Western" psychiatry is a rather recent phenomenon. The health-related activities of international development agencies and especially national health ministries in developing countries have, for a long time, shown little interest in mental health issues. This was partially due to the fact that international health professionals have tended to exclude mental illness from standard assessments of global health (Desjarlais et al. 1996: 4). This situation, however, has begun to change recently. Increasingly, the WHO stresses that mental disorders make substantial contributions to the global burden of disease (GBD) while the proportion of those people with mental disorders who would need treatment but receive no or inadequate mental health care – the so-called "treatment gap" – is estimated at

around 80% for low and middle-income countries (www.who.int/mental_health). Global and national institutions are therefore currently investing massively in the export of “Western” psychiatric techniques.

Such developments have been reflected upon critically in historical (e. g. Bhugra 2001) and contemporary perspectives (e. g. Watters 2010). Although ideas of the universality of psychiatric models and therapies are extremely powerful, many anthropological studies have shown that behavioral and psychological disturbances in non-Western settings cannot be easily equated with the categories of Western psychopathology, and that seemingly appropriate categories often have a significantly different meaning in local contexts (Kleinman’s classic “category fallacy” 1977). While such studies focus primarily on diagnostic categories, there are few comparable in-depth studies of how psychiatry is actually practiced in various local contexts outside the North-Atlantic world. Indeed, there are scientific, professional, institutional, economic and peer pressures on psychiatrists to emphasize the transculturally similar aspects of their practice and to downplay local differences. Even if psychiatrists the world over have (more or less) similar teaching curricula, use the same diagnostic manuals, and prescribe the same drugs, they differ in their actual treatment and the take-up of the treatment by patients varies greatly; the health benefits of (and the harm caused by) their various treatments are therefore not the same.

Quack’s current research project engages with the recent export of “Western” psychiatry, and addresses problems related to the translation of concepts and practices from psychiatry into North Indian realities. This work is part of the author’s long-term interest in issues of “mental health” in India. During his doctoral fieldwork on rationalist organizations and their criticism of “traditional” healing practices (Quack 2011) he focused especially on the criticism of religious healing sites. His work included short ethnographic field studies on “traditional” mental health-care at Balaji temple, Mehandipur, India and visits to “traditional” mental health-care sites such as the Vineyard Workers’ Church (Pune), the “exorcist” Abid Kadiri (Ahmednagar), the Mirawali Durgah (Ahmednagar), the Mahanubhav Temple

(Phaltan), Farshiwale Baba (Nasik), and Mira Dattar Durgah (Palanur). In addition, Quack conducted interviews with psychiatrists, mental health activists, various NGO representatives, and self-help groups in Maharashtra and Delhi.

Against this background, Quack’s current research aims can be divided into two parts. The first part is an ethnographic study of a psychiatric wing of an urban hospital in the state of Uttarakhand in North India, based on long-term fieldwork conducted there in 2010. It contributes to the small group of researchers working on the actual practice of “Western” psychiatry in India (e. g. Addlakha 2008; Jain and Jadhav 2008, 2009) and other non-Western countries (e. g. Higginbotham 1984; Gaines 1992).

The psychiatric system adopted from the West is practiced in a specific way in India. The most important difference is the lack of institutionalized mental health care infrastructure, i. e. psychiatrists, psychologists, additional therapeutic care and social workers. The two most significant implications of this shortage of health professionals are the very short consultation times the therapists can dedicate to each patient, and the great distances that many patients must travel to reach the doctor, when and if one is available and affordable. Further problems of infrastructure are that not only mental health professionals but also some of the medicines are not available to or affordable for the patients. The mental health care situation in Uttarakhand was summarized by a WHO report from 2006 in the following words: “Uttarkhand is a new state and it lacks in sufficient infrastructure, manpower, and facilities. The state has neither a mental hospital nor a community mental health facility. There is no specific mental health related information system in the state [...]. Only 3.22 percent of the total planned budget for the year 2005-06 has been earmarked for health of which only 1.2 percent (INR 106.61 lakh [“lakh” is a unit in the Indian numbering system equal to one hundred thousand]) has been allocated for establishment of a Mental Health Authority and the construction of a mental hospital. The state does not have a mental health outpatient facility in the public sector.” (WHO 2006: iv-v)

In general, this assessment still held true in

2010. The major difference from 2006 is that the state has a new Mental Hospital, in Selaqui near Dehradun. It was not offering full service when Quack last visited in October 2010, but had begun to treat the first few inpatients. Beside this, the only mental health outpatient and day treatment facility is available at the

Himalayan Institute Trust Hospital near Dehradun. The dimension of the described lack of trained staff becomes most visible if compared to a Western country of the same size and roughly the same amount of inhabitants such as Switzerland.

per 10,000 population	World	S-E Asia	India	Uttarkhand	Switzerland
Total Psychiatric Beds	1.69	0.33	0.25	Nil	13.2
Psychiatric beds in mental hospitals	0.33	0.03	0.05	Nil	13.2
per 100,000 population	World	S-E Asia	India	Uttarkhand	Switzerland
Number of psychiatrists	1.2	0.2	0.2	0.08	23
Number of neurosurgeons	0.2	0.03	0.06	Nil	0.8
Number of psychiatric nurses	2.0	0.1	0.05	Nil	46
Number of neurologists	0.3	0.05	0.05	Nil	3.4
Number of psychologists	0.6	0.03	0.03	0.01	40.8
Number of social workers	0.4	0.04	0.03	Nil	106

Table. 1: Psychiatric Beds and Professionals in Mental Health (Sources: for Uttarkhand WHO 2006: 6, for Switzerland WHO 2005: 449)

Thus, in the years 2005/06 there were 287.5 times more psychiatrists in Switzerland than in Uttarakhand, and 4080 times more psychologists, not to speak of the trained social workers of which Switzerland has more than one per 1000 inhabitants while Uttarakhand has none for more than 8.5 million inhabitants. Despite the fact that Switzerland is a comparatively rich Western country, it does not take much imagination to see that there is an enormous mismatch between the infrastructure within which psychiatric medicines and the respective therapeutic interventions are planned, tested and implemented in other parts of the world, such as India, where they are transplanted into a completely different infrastructure. The lack of infrastructure and time are two of the most important reasons for the psychiatrists' almost exclusive use of prescription drugs for the treatment of the "mentally ill" in places like Uttarakhand. Other aspects of mental health-care such as psychotherapy, social work, or self-help groups were non-existent in Uttarakhand in 2010. Studies on the quantities and ways in which psychotropic drugs are prescribed in India have been conducted, for example, by Baby et al. (2009), Ecks and Basu (2009) and Jain and Jadhav (2009). The question as to why psychiatrists rely almost exclusively on pharmaceutical or somatic interventions in psychiatric settings has been addressed head-on by Nunley (1996) and Jain and Jadhav (2009). In addition to the lack of infrastructure

they highlight the importance of mental health planning and policy-making.

A further important observation is that patients in India do not take drugs as prescribed. An extensive review of the literature on compliance (e. g. Cohen, Ross et al. 2004; Cramer et al. 2008; Elliott et al. 2008) leads to several observations. Firstly, a whole series of problems are often lumped together under the rubric of "compliance". These include issues such as the patient "health literacy", the available health care alternatives, the multilayered realm of doctor-patient relationship and the debates around drug side effects. Secondly, this set of problems results in forgone health benefits, new health problems and increasing productivity costs. A number of patients, for example, discontinue antipsychotics after some time because they do not feel relief from symptoms like hallucinations or delusions and, additionally, the medications can be quite expensive. The underlying problem is that the antipsychotic medicines they got only show efficacy after two to eight weeks of continuous and correct intake. The Indian patients, some of whom have a generalized perspective on biomedicine as being "fast" and "aggressive" (see also Halliburton 2009: 14, 116, 190-195), are therefore unlikely to spend a considerable amount of money on medicines that appear ineffective to them.

Although the set of problems generally summa-

rized under the rubric “compliance” is enormous the world over there are two reasons why this issue has to be highlighted especially in the present case. Firstly, psychotropic medications represent the mainstay of treatment in India. Kumar and Sedgwick (2001: 280) argue that this is the case in countries with emerging and developing economies in general. Secondly, there are many reasons why patients do not follow the treatment regime as proposed by the doctor, i. e. why “non-compliance” is particularly high in settings such as this one. Therefore it is crucial to investigate the larger phenomenon of “compliance” (or “adherence”), particularly with a focus on the patients’ perspectives. The research in India by Quack further suggests that a significant factor is counseling by health professionals, including the adequacy of their communication and gained trust (see also Chue 2004; Eley et al. 2006). Of central importance is the fact that the patients’ perspectives on the origins, central aspects and probable ways of addressing their problems are more or less ignored by psychiatrists. These and related observations are supported by Baby et al. (2009) who argue that the majority of noncompliant patients in India are less educated, and live in rural areas. The follow-up counseling for these patients is limited in scope as the psychiatrists are typically overburdened with heavy patient load. Family members and patients are reluctant to ask questions about their medication and treatment and most of their doubts remain unaddressed. The majority of the psychiatrists interviewed in Uttarakhand attributed non-compliance to the patients’ lack of mental health “awareness”. They described how some patients have generalized prejudices about psychotropics such as the idea that biomedicine is fast and aggressive and hence the patients stop medication if there is no immediate effect. The psychiatrists hardly reflected on the question whether the differences in education and habitus were also a hindrance to their treatment approach. Such observations should not be taken as criticism of the psychiatrists given the time pressure under which they have to work and the fact that they are trained in natural and not social sciences. The challenges they face every day are considerable. For example, the doctors do not only have to translate from medical terminology to everyday speech, from English to Hindi and further – often via a third person – to Garhwali (the

language spoken by most of the people living in the northern Garhwal Division of Uttarakhand). But they generally also have to translate from the logic of the Western textbooks to the local realities of the patients. The “Western” psychiatric system only works if the patients are able to understand and follow the underlying therapeutic logic. This is often not the case in Uttarakhand, not only because patients are at times not able to read and write, but, more importantly, because the approach of the Western-educated urban middle-class doctor clashes with the “habitus” of the patients. Addlakha, whose research produced similar findings as those presented here, concluded: “For Indian practitioners, medical training is a double socialization, that is, into psychiatric nosologies and treatment regimes, and into the culture of biomedicine. [...] The challenge to indigenous professional practitioners, trained in a system that has developed in the context of an alien society and culture, but applying it to their own societies, is to negotiate their own commonsensical understanding with the so-called objective and universal discourse of the biomedical model.” (2006: 265-266)

This is much less true when one looks at the traditional healing sector in India. In this respect the statement about the lack of mental health infrastructure has to be qualified. The facts and figures about the number of psychiatrists, hospitals, beds, etc. in India take into account only some aspects of mental health care. Mental health authorities and public health research nearly always ignore the significance of therapeutic alternatives for the mainstream medical system. The former head of the Psychiatry Department at the All-India Institute of Medical Sciences, New Delhi, and WHO consultant Jaswant Singh Neki estimated in 1973 that around 80% of the Indian population approaches “folk” practitioners and “traditional” healing centers for treatment of mental health problems (see Pakaslahti 1998: 129). This figure has been subsequently confirmed by various other studies (see Kapur 1975, 2004; Campion and Bhugra 1997: 215; Shah 1984: 737; De Sousa and De Sousa 1984: 6). India has a network of health practitioners operating outside the institutionalized health-care system, often outside the purview of health professionals (see Pakaslahti 1998: 129). This

“traditional” healing system provides the bulk of care and support for those who suffer from mental health and substance-dependence problems. On the question of the relationship between the “traditional” alternatives favoured by psychiatric patients in India, there are several good anthropological studies (see for similar findings Basu 2009a,b, 2010a,b; Bibeau and Corin 2009, 2010). The first comparative approach addressing this question is provided by Incayawar et al. (2009).

Practically all Indian psychiatrists that Quack spoke to were partially aware of the observations listed above. On the other hand, this partial awareness had no bearing on their professional practice. Despite the fact that in interviews and every-day conversations most psychiatrists questioned the exclusive prescription of drugs, complained that far too many patients failed to take medicine as prescribed, and confirmed the importance of engaging with the patients’ and healers’ explanatory models, religious beliefs and practices, these “insights” had few if any further consequences. Why does the everyday knowledge of psychiatrists not influence their professional practice? Our hypothesis, to be developed in future publications, is that they are faced with a dilemma: on the one hand, psychiatrists want to stay true to their professional training while on the other hand this stance sometimes conflicts with the local realities. The cultural psychiatrist Fabrega summarizes his as well as the findings of the anthropologist Nunley (1996) with the following words: “To act like a doctor in India is to take an epidemic view, deal rapidly with a heavy patient load, quickly make provisional disease diagnoses, and prescribe drugs. To handle problems that are brought to them in any other way would make psychiatrists less like other doctors and more like gurus, spiritual counselors, or faith healers, which are not what psychiatrists in India want to be.” (Fabrega 2009: 614)

The fact that the therapists generally tend to privilege abstract, professional knowledge over knowledge gathered in their every-day lives (*lebensweltliches Wissen*) is well recognized. This can reach such extent that the professionals become structurally blind to or “misrecognize” (in Bourdieuan terms) problems that appear to be clearly visible from an outsider’s

perspective. It was observed, for example, that psychiatrists often prescribe medicines that they (should) know the patients cannot afford. They also often condemn religious beliefs and practices they themselves adhere to in their private lives. Furthermore, when asked about the relevance of issues related to “culture” in their practice, the “culture-bound syndromes” as listed in the international manuals come to their mind, but not the many ways in which these manuals do not fit their therapeutic realities. Grundmann et al. (2008) convincingly argue that this discrepancy is the more pronounced the higher the perceived asymmetry between professional and every-day knowledge. With respect to India, it is important to note that “Western” psychiatry is one of many colonial relics that unfolds with specific dynamics in the post-colonial context (Ananth 1981; Bhugra 2001; Bhugra and Littlewood 2001; Jadhav 2004; Fabrega 2009). “Western medicine” or “English medicine” (as it is also called in India) continues to carry high prestige and is often opposed to “superstition” and “backwardness”.

Such factors help to explain why the psychiatrists studied in India do not engage with those experiences and understandings of their patients which feature non-biomedical interpretations of their problems such as social circumstances, relationship problems, broken taboos, or further religious explanations. Accordingly, many patients turn to the therapies of traditional healers who engage with such issues.

The second part of Quack’s project attempts to compare the ethnography of psychiatric practices in North India with similar studies in different cultural contexts. We lack comparative studies of the many ways in which psychiatry is practiced in different local settings. Such studies would help us to identify commonalities and differences between local psychiatries, especially in non-Western countries, and this could represent the basis for improving mental health services. Quack plans to research the ways in which his observations on the practice of psychiatry in India can be compared to similar studies in other countries in 2012 when he will become a research fellow at the Division of Social and Transcultural Psychiatry, McGill University, Montreal. The aim of the project is to contribute to a more comprehensive understanding of how different cultural contexts

shape, transform, or even corrupt psychiatric practices by engaging with ethnographies of psychiatry that take into account the psychiatrists', patients' and care-givers' experiences and perspectives. A "radically empirical" (ethnographic) approach is crucial, since the descriptive language prevalent in standard "Neo-Kraepelinian" (Gone and Kirmayer 2010) depictions of psychiatric practices tends to hide cultural differences while projecting apparently universal features.

Contemporary Āyurvedic Nosology and the Influence of Biomedicine

The spread of biomedicine to India in the 19th and 20th century did not fail to have an impact on the indigenous scholarly medical tradition of Āyurveda. Chopra's project on the nosology of contemporary Āyurveda aims to analyze the complex processes brought about by this trans-cultural flow. Nosology has been chosen as the object of research because this is the part of medicine where practice is intimately related to the theory of the relevant "medical system". When the physicians assess signs and symptoms of the patient and classify them so as to name one or more disease(s), they apply the categories of their medical system to the realities of diseased patients and at the same time the medical system is confronted with the realities of disease. Therefore, one can assume that changing medical realities have an impact first and most clearly on a medical system's nosology. The study of nosology may thus also offer insights into patterns of change within a particular medical system. To research these processes, Chopra combined field-work in Āyurvedic clinics in India with a study of contemporary scientific literature of Āyurveda; in addition, results of historical-philological research, at least on the major historical works of the Āyurvedic tradition, had to be surveyed, because Āyurveda is typically defined as a traditional science and physicians as well as learned authors constantly refer to traditional literature (Zimmermann 1978).

A most conspicuous effect of the influence of biomedicine on Āyurveda is the process termed "professionalization" (Leslie 1998 ?1976?), which in the course of the last century has resulted in the institutionalization of Āyurveda along the lines of biomedicine. Thus, Āyurveda

is presently taught in colleges according to a centrally sanctioned curriculum and Āyurvedic physicians obtain their own registration and form their own professional associations, to name just the most visible effects. These developments in the institutional representation of Āyurveda clearly reflect an asymmetry with biomedicine as the dominant partner. However, when we go beyond these external representations and ask if and how biomedical concepts have influenced the practice and the scholarly aspect of Āyurveda, the picture becomes more complex. As medical systems in general can be considered practical sciences, research should at best include practice as well as scholarly theory in order to do justice to a learned medical system like Āyurveda.

Two short periods of field-study in two very different Āyurvedic clinics in India reveal that there is noticeable diversity in the practice of Āyurveda in India. The first such study was conducted over five months at a reputed modern academic institution of Āyurveda in north India, which to a large extent is typical of contemporary "professionalized" Āyurveda, while the second field-study took place for about three months in the clinic of a highly respected traditional Āyurvedic physician in south-west India.

The presence of biomedicine is clearly felt in both institutions, thus in both institutions reports of biomedical (laboratory) tests are routinely taken into consideration when diagnosing a patient and they are sometimes even specifically asked for. In the clinic of the academic institution even external elements of the clinical encounter resemble those of biomedical institutions, so that the physicians, for example, often wear white coats and carry a stethoscope. In the traditional clinic, on the other hand, the consultation takes place in more family-like circumstances and the physician, who happens to be a high-caste Brahmin, wears his traditional attire and his main diagnostic techniques are looking at the patient and questioning him, while he rarely palpates e. g. the abdomen of a patient in the case of abdominal swellings or liver-enlargement.

Documentation in the professionalized institution routinely takes place in English, even though the conversation with the patient is usu-

ally in Hindi. In many cases, though not always, even the diagnostic category noted down is drawn from the biomedical nomenclature. Although there is a dispensary of Āyurvedic medicines produced in the university itself, where patients could procure medicines, the doctors show a clear predilection for prescribing the so-called “proprietary” Āyurvedic medicines, pharmaceuticals produced by companies on the basis of traditional Āyurvedic recipes, which are modified to a greater or lesser extent and thus become the “property” of the company. This process of prescription and subsequent procurement of industrially produced medicines from an (Āyurvedic) pharmacy might also be seen as an emulation of biomedical patterns. During the Chopra’s own field-research in this institution of professionalized Āyurveda, the prescription of biomedical drugs by physicians trained in the institutionalized Āyurveda, described as a frequent practice in the literature, was witnessed only very rarely.

With respect to these practices the difference between the clinic of the professionalized Āyurvedic institution and the traditional physician seems to be most pronounced. In the traditional physician’s clinic the diagnosis is routinely noted down as an Āyurvedic disease-name (Sanskrit in Malayalam script), with the English biomedical disease name sometimes noted in addition. Interesting to note is that at times this practice implies a translation which is tacitly performed. Thus, when asked about his problem, a young male patient replies that he has been diagnosed with ulcerative colitis, employing the English disease name in the course of a conversation taking place in Malayalam. The physician’s assistant notes down the Āyurvedic disease name *grahaṇī* without any discussion. However, such acceptance of a biomedical diagnostic category, and its translation into an Āyurvedic one, is not a common practice in this clinic. In most cases the physician insists on making his own, Āyurvedic diagnosis on the basis of his own diagnostic means, even if the patient presents him with a biomedical disease name. On the basis of this diagnosis the physician then dictates his prescription, usually consisting of numerous herbal preparations of different kinds (decoctions, powders, oils, pastes etc.) and their combination, all of which is noted down by the assistant. While dictating the prescription the physician very often recites

Sanskrit verses from classical texts (most often from the *Aṣṭāṅgahṛdayasaṃhitā*, but also from the *Aṣṭāṅgasamgraha*, the *Sahasrayogam*, the *Cikitsāmañjari* and others), describing the formulation and the indications of the respective preparation. Almost all of the preparations that he prescribes are found in the classical texts, the rest consisting of variations of classical formulations created by the physician himself. While prescribing these classical herbal remedies, the physician commonly combines or mixes the preparations so as to suit the needs of the individual patient. To make the clinical encounter complete, a factory for these herbal preparations also belongs to the estate of this traditional physician. Therefore, the patients usually take the prescription to the physician’s own dispensary where the remedies and their specific combinations are prepared for them. These freshly combined individual preparations are then taken home by the patient, together with a couple of typed pages containing information on how to take the medicines and including dietetic advice, too.

As these short sketches of two different instances of Āyurvedic consultations show, there is a marked diversity in the actual clinical practice of Āyurveda. However, when it comes to the question of the impact of biomedicine on Āyurveda and specifically to the question of how biomedicine influences Āyurvedic nosology, one finds that the differences between different contemporary practitioners of Āyurveda are not as great as suggested by the observation of practice. Taking a close look at the way diseases are presently named and conceptualized, we may roughly distinguish three patterns.

The first pattern is represented by the rare instance where a modern biomedical disease is accepted as being a separate disease, not regularly found in the traditional Āyurvedic literature. A case in point may be hypertension (“high blood-pressure”), which is mostly accepted as a separate disease and then even translated into Āyurvedic parlance by being accorded a “new” Sanskrit name. (Although there is diversity here, too, see Chopra n.d.)

The second pattern is seen at the other extreme, that is, the Āyurvedic disease-entities continue to exist in their own identity. An example of this from the practice of the traditional Āyurvedic

physician in south-west India is the disease-entity usually called *raktavāta* by him (in the literature it is more often known as *vātarakta*); this comprises symptoms such as lower back pain and pain in the knee-joints. In these cases the physician ostentatiously refused to look at biomedical diagnostic reports (e. g. CT-scans, MRI-scans, X-ray-films) even if the patients brought them along. Instead, he examined the knees and the skin of the legs in accordance with the description of this disease-entity in the classical texts: needless to say, the therapy, too, followed the classical Āyurvedic lines. As is to be expected, this pattern of a classical Āyurvedic disease-entity retaining its own identity is more frequently seen in the traditional Āyurvedic practice than in the practice of professionalized Āyurveda.

However, the third and by far the most common pattern in both types of contemporary Āyurvedic practice is characterized by a complex process of translation on the basis of correspondences between modern biomedical diseases and classical Āyurvedic disease-entities. Although this process has clearly perceptible bearings on everyday practice, one might perhaps get a clearer idea of this kind of process by taking a look at textbooks and other literature produced by contemporary Āyurvedic scholars. Studying the ways in which diseases are defined, classified and described in typical contemporary text-books of Āyurveda, one notices a translation-process on different levels: firstly, there is translation in the popular sense of the word, meaning linguistic translation; secondly, and more importantly, there is translation based on disease-symptoms; and thirdly, we find attempts at translating physiological concepts. As an example the disease named *prameha* may be cited, a disease name well known from the Āyurvedic tradition, starting with the earliest extant texts (for a critical historical discussion of this disease-entity see Müller 1932). A number of disease-conditions characterized by excessive discharge of urine and/or abnormalities of urine are subsumed under this term (the classical theory mostly knows of twenty different types of *prameha*) which can be translated literally as “excessive urination”. Nowadays this term has become almost synonymous for the biomedical disease-entity of diabetes mellitus and is very often defined by the biomedical parameters that

define that disease. Thus the traditional physician in south-west India routinely asks his patients if they suffer from *prameha*, using this Sanskrit term in his (Malayalam) conversation and if the answer is affirmative, he asks for the result of the latest blood sugar test (referring to the result of a biomedical laboratory test). Clearly to him as well as his patients the term *prameha* is synonymous with the disease that is defined by an abnormally elevated level of blood sugar. This identification of *prameha* with diabetes mellitus is partly enforced by the fact that the Greek term diabetes like the Sanskrit term *prameha* means “excessive urination”; in addition, at least one of the varieties of *prameha* described in classical Āyurvedic texts is characterized by an excessive discharge of sweet urine, usually referred to as *madhumeha*, the meaning of which corresponds to the biomedical term diabetes mellitus, viz., “excessive discharge of honey-sweet urine”. (One might note in passing that in this case the biomedical disease name reflects a historically older stage in the history of modern biomedicine.) Thus, this translation based on the similarity of symptoms coincides with a semantic similarity of disease terms from different medical cultures. By narrowing down the meaning of *prameha* to signify what in traditional scholarship is only one of its numerous varieties, namely the condition of discharging sweet urine, the term becomes synonymous with diabetes mellitus. This process of translation creates wider repercussions in the nosological system: *prameha* in this new understanding is the Āyurvedic term for diabetes mellitus, but this particular form of *prameha* is not counted among the diseases of the urinary tract any more, where it would be placed according to classical Āyurvedic ideas of the disease-process. Rather, it becomes a metabolic disease and is treated as such, albeit with Āyurvedic means.

This example shows that biomedical concepts have at times a formative influence on the formulation of contemporary Āyurvedic theory and thus this seems like a clear instance of asymmetrical translation demonstrating the dominance of biomedicine. However, if we take a closer look at the process of translation that is carried out here and ask ourselves why such great pains are taken to effect a translation in the first place (would it not be easier to just take over biomedicine wholesale as it is and not

bother about translations?) this clear-cut judgment becomes fuzzy. In general, the process of translation presupposes that the target language is, at least broadly, as capable of expressing facts as the source language is. Or, to apply this commonplace notion to the case at hand, the presupposition here is that the science of Āyurveda and its idiom are as capable of conceptualizing diseases as modern biomedicine is. Taking this idea further, we cannot avoid asking how the contemporary proponents of Āyurveda view the status of their own science vis-à-vis biomedicine. Considering the fact that biomedicine with its close relationship to the modern natural sciences has a strong if not exclusive claim to being based on and representing scientific truth, the question arises what the ontological status of Āyurveda and its own epistemological foundation would be in relation to biomedicine. Surveying the writings of contemporary proponents of Āyurveda (mainly text-books written by learned authors in modern Indian languages like Simha 1994-2001, Shukla 1997) and discussing this question with Āyurvedic doctors personally, one comes to notice a rather unexpected kind of asymmetry, according to which it is the science of Āyurveda as embodied in the tradition which is actually representing true and complete knowledge. Or, as a highly respected retired professor of Āyurveda pointedly formulated it, “Āyurveda is a developed science while modern medicine is a developing science” (Ram Harsh Singh, Varanasi, personal communication, March 2010). This idea is based on a classical notion of science, which is deeply rooted in Indian culture (and has been described by Pollock [1985] in a seminal article). According to this classical notion, a *śāstra*, a “traditional science” is true and complete; it is “primordial” as it is typically said to have been revealed by the creator himself. This concept is often combined with a narrative of parts of the science having become lost in the course of history; any kind of scientific progress is in this context understood to be only a rediscovery of lost parts of the *śāstra*. This narrative is not limited to the traditional sciences of the Indian culture but is also reflected in a general historical discourse which forms part of the so called renaissance of Indian culture in the 19th and 20th century (cf. Leslie 1992 and 1998). A recurring motif in this discourse is the notion of an ancient golden era of the Indian culture, the achievements of which were lost or

even suppressed during the intervening era of foreign dominance (first by Muslims, then Europeans, to put it simply). So if contemporary proponents of Āyurveda identify the modern biomedical disease-entities with classical Āyurvedic diseases, they are re-constituting lost knowledge and at the same time taking part in the larger cultural project of reclaiming an alleged golden era of Indian culture.

Thus, we see that in addition to the apparent dominance of biomedicine there is a different kind of asymmetry, one that is perhaps not as easily perceptible as the first one, in which Āyurveda happens to be the dominant partner. Āyurveda thus incorporates biomedical ideas by translating them into its own system without giving up fundamental Āyurvedic notions. Seen from a more traditional perspective the processes sketched above would be described as an incorporation of biomedical ideas into the – true and complete – science of Āyurveda and not as an example of biomedical influences on it. For the status of Āyurveda and its contemporary proponents this means that they strongly assert the validity of their own medical tradition in this age when biomedicine is dominant. The fact that the arguments for this proposition coincide with and are enforced by a larger discourse in contemporary Indian society reminds us that even developments in the seemingly autonomous field of medicine cannot be viewed in isolation from the social and political context. In this context one should not forget that biomedicine and Āyurveda in contemporary India not only compete for scientific validity, but also for political influence and finances. Presently, it is biomedical institutions that receive by far the largest share of public finances.

Conclusion

In the two projects presented here the complexity of the translation processes involved in the transcultural flow of biomedicine is clearly evident. These processes of translation are informed by the scientific concepts of biomedicine as much as by concepts of the respective other medical system, be it lay-concepts of psychic disease as in the case of psychiatry in rural north India or scholarly concepts of Āyurveda. Cultural and social circumstances might enforce certain aspects of these translations as well as

economic factors, such as the allocation of public spending on health. In the long term these translation processes might even change the face of biomedicine and result in very local manifestations of an allegedly global scientific medical system.

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Stress and Modern Work: Ethnographic Perspectives from Industries in Bangladesh

Christian Strümpell, Hasan Ashraf

Introduction

Less than a century ago Western medical science developed the concept “stress” which, after the Second World War, was rapidly taken up and disseminated by the mass media and since then permeates everyday discourse (Young 1980: 133). In Western Europe and North America, stress is *the* dominant trope on the

predicament of modern fast-paced and success-oriented societies, especially in the context of modern work. About one out of four European workers reports having to work at very high speed all or almost all the time, and in the USA one out of four workers complains about being frequently burned out or stressed by his or her job (European Foundation for the Improvement of Living and Working Conditions 2006).